

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION?
YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

20. WEEK 52 IS THE WEEK BEFORE THE INJURY							
WK	WEEK ENDING	GROSS EARNINGS	WK			WK	
1			19			37	
2			20			38	
3			21			39	
4			22			40	
5			23			41	
6			24			42	
7			25			43	
8			26			44	
9			27			45	
10			28			46	
11			29			47	
12			30			48	
13			31			49	
14			32			50	
15			33			51	
16			34			52	
17			35			21. TOTAL EARNINGS \$	
18			36			22. GROSS AVERAGE WEEKLY WAGE \$	

23. PREPARER NAME AND TITLE (TYPE OR PRINT):	24. TELEPHONE NUMBER:	25. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB 2 (8/94)